

**MICHIGAN DEPARTMENT OF  
COMMUNITY HEALTH**

**COMPANION GUIDE  
FOR THE HIPAA  
837 PROFESSIONAL ENCOUNTER  
ADDENDA  
VERSION 4010A1**

**Medicaid Health Plans (MHPs), Special  
Health Plans (SHPs), County Health Plans  
and MIChild Health Plans**

**September 23, 2003  
(Updated December 20, 2004)**

*Michigan Department  
of Community Health*





MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health Plans**

i

DATE

**12-20-04**

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)** dated May 2000. This document should be used in conjunction with all MDCH encounter submission and processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The Addenda implementation guide can be found at [http://www.wpc-edi.com/hipaa/hipaa\\_40.asp](http://www.wpc-edi.com/hipaa/hipaa_40.asp). HHS guidance on data clarifications can be found at <http://aspe.os.dhhs.gov/admnsimp/q0321.htm>.)

NOTE: **Page references** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)** ("Version 4010"), unless otherwise noted (with an asterisk (\*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim Addenda, ASC X12N 837 (004010X098A1)**.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**1**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
62		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide.  Submissions with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected.
65		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use “RP” – Reporting.
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X098A1” if using the October 2002 Addenda Implementation Guide.
69	1000A – Submitter Name	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code).
75	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
78	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with “1” and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
14*	2000A – Billing/Pay-to Provider Hierarchical Level	PRV – Billing/Pay-to Provider Specialty Information	PRV03 – Provider Taxonomy Code	MDCH requires taxonomy code to identify the provider specialty. MDCH expects the HIPAA-mandated Health Care Provider Taxonomy Code List will be used to identify the specialty code.
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the EIN or SSN value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier).
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider use their state license number.

\*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



MANUAL TITLE <b>COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health Plans</b>		<b>2</b>
		DATE <b>12-20-04</b>

Page	Loop	Segment	Data Element	Comments
110	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH's level of responsibility use "S" if the capitated plan is the only payer (that is, patient has no other insurance), "T" if there are any other payers.
111	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use "MICHILD" for children enrolled in the MICHild Program. Use "ABWI" for those enrolled in the Adult Benefit Waiver Phase I Program.
112	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use "MC" (Medicaid) for Michigan Medicaid, "TV" (Title V) for CSHCS, "OF" (Other Federal) for MICHild or Adult Benefit Waiver Program Phase I. If recipient qualifies for more than one program, or other MDCH program not listed, use "MC" (Medicaid).
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification Number).
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient's 8-digit beneficiary ID number assigned by MDCH. For MICHild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker.
126	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY" (Social Security Number).
127	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Use the patient's Social Security Number.
131	2010BB – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use "PI" (Payor Identification).
131	2010BB – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use "D00111" for MDCH.
152	2000C – Patient Hierarchical Level			MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set.  Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**3**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
170	2300 – Claim Information			Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information within each Loop 2000B (Subscriber Hierarchical Level).  Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Level) will be rejected.
173	2300 – Claim Information	CLM – Claim Information	CLM05-1 – Facility Code Value	Place of service codes are defined by the Center for Medicare and Medicaid Services (formerly HCFA). These codes can be obtained at <a href="http://cms.hhs.gov/state/poshome.asp">cms.hhs.gov/state/poshome.asp</a>
173	2300 – Claim Information	CLM – Claim Information	CLM05-3 – Claim Frequency Type Code	Use “1” on original encounter submissions; use “7” for encounter replacement, and use “8” for encounter void/cancel. For both “7” and “8”, include the original Encounter Reference Number (ERN), as indicated in Loop 2330B REF02 (Original Reference Number).
217	2300 – Claim Information	CN1 – Contract Information	CN101 – Contract Type Code	MDCH requires this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.
247	2300 – Claim Information	NTE – Claim Note	NTE01 – Note Reference Code	Use “ADD” (Additional Information).
247	2300 – Claim Information	NTE – Claim Note	NTE02 – Claim Note Text	Provide free-text remarks, if needed.
265	2300 – Claim Information	HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	MDCH requires this element on every encounter. Do not use a decimal point.
40*	2310A – Referring Provider Name	PRV – Referring Provider Specialty Information	PRV03 – Provider Taxonomy Code.	MDCH requires taxonomy code to identify the provider specialty. MDCH expects the Health Care Provider Taxonomy Code List will be used to identify the specialty code.
288	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
289	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF02 – Referring Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM109 – Rendering Provider Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310B REF02 (Rendering Provider Secondary Identifier).

\*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**4**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
41*	2310B – Rendering Provider Name	PRV – Rendering Provider Specialty Information	PRV03 – Provider Taxonomy Code	MDCH requires taxonomy code to identify the provider specialty. MDCH expects the HIPAA-mandated Health Care Provider Taxonomy Code List will be used to identify the specialty code.
296	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
297	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF02 – Rendering Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
319	2320 – Other Subscriber Information	SBR – Subscriber Information		This loop will be used once for the capitated plan and once for each other payer.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code “P” or “S”, as appropriate, and the capitated plan coverage with “S” or “T”, as appropriate. If the patient has no other insurance, report the capitated plan coverage with “P”.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father's insurance, use code “19” (Child).
320	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the capitated plan or other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
321	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR05 – Insurance Type Code	Use “MC” (Medicaid) for Medicaid Health Plan, “OT” (Other) for MICHild Health Plan or Adult Benefit Waiver Program Phase I Health Plan. Additional payers should be identified using the appropriate code.
351	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the capitated plan or other payer.

\*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**5**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use “MI” (Member Identification Number).
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the capitated plan or other payer indicated in Loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
357	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1W” (Member Identification Number).
360	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use “PI” (Payor Identification).
361	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the capitated plan, use the 9-digit Payer ID assigned by MDCH, for example 171234567. For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be “00029005”. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”.
368	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF01 – Reference Identification Qualifier	For the capitated plan, use “F8” (Original Reference Number).
369	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF02 – Other Payer Secondary Identifier	For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.
370	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	Use “9F” (Referral Number) or “G1” (Prior Authorization Number).
371	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number (Loop 2300 REF02 - Prior Authorization or Referral Number), which is specific to the destination payer.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**6**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
380	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
384	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
388	2330F – Other Payer Purchased Service Provider	REF – Other Payer Purchased Service Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
392	2330G – Other Payer Service Facility Location	REF – Other Payer Service Facility Location Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
396	2330H – Other Payer Supervising Provider	REF – Other Payer Supervising Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
398	2400 – Service Line			The HIPAA Implementation Guide allows up to 50 repetitions of the 2400 Service Line Loop for each 2300 loop.
56*	2400 – Service Line	SV1 – Professional Service	SV101-1 – Product/Service ID Qualifier	Use “HC” Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.
56*	2400 – Service Line	SV1 – Professional Service	SV101-2 – Procedure Code	MDCH expects the Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes to be reported for each service line.

\*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**7**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
402	2400 – Service Line	SV1 – Professional Service	SV102 – Line Item Charge Amount	MDCH requires the provider's usual and customary charge or billed amount. Zero (0) is a valid amount if: <ul style="list-style-type: none"> <li>1) the health plan has a subcapitated contract arrangement with the provider as designated in Loop 2300 CN101 (Contract Type Code) or Loop 2400 CN101 (Contract Type Code) and the contract permits zero as a charged amount, or</li> <li>2) the service(s) is/are recognized by MDCH as having no associated charge(s), for example, vaccines.</li> </ul>
466	2400 – Service Line	CN1 – Contract Information	CN101 – Contract Type Code	MDCH requires this data element for encounters where the health plan contract arrangement with the provider is other than fee-for-service.
485	2400 – Service Line	AMT – Monetary Amount	AMT02 – Approved Amount	MDCH requires the health plan's fee-screen or maximum allowable amount for the service(s) reported when the contract with the provider is fee-for-service. Zero (0) may be an appropriate value if the health plan never covers the service. The health plan is not required to report this data element when the contract arrangement with the provider is subcapitated, as designated in Loop 2300 CN101 (Contract Type Code) or Loop 2400 CN101 (Contract Type Code).
73*	2410 – Drug Identification	LIN – Drug Identification	LIN03 – National Drug Code	This element may be used to report prescribed drugs that may be part of the service(s) described in Loop 2400 SV1 (Professional Service).  MDCH will only process the first iteration of Loop 2410 LIN (Drug Identification). Any additional repeats may be ignored.
79*	2420A – Rendering Provider Name	PRV – Rendering Provider Specialty Information	PRV03 – Rendering Provider Taxonomy Code	MDCH requires taxonomy code to identify the provider specialty. MDCH expects the HIPAA-mandated Health Care Provider Taxonomy Code List will be used to identify the specialty code.
554	2430 – Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information).

\*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



MANUAL TITLE

**COMPANION GUIDE FOR THE HIPAA 837 PROFESSIONAL  
ENCOUNTER, VERSION 4010A1 for MHPs, SHPs and MICHild Health  
Plans**

**8**

DATE

**12-20-04**

Page	Loop	Segment	Data Element	Comments
555	2430 – Line Adjudication Information	SVD – Service Line Adjudication	SVD02 – Service Line Paid Amount	MDCH requires the amount paid to the provider. Zero (0) is an appropriate value if: <ul style="list-style-type: none"> <li>1) the service was not covered by the health plan, or</li> <li>2) the service was covered under a subcapitated contract arrangement.</li> </ul>
560	2430 – Line Adjudication Information	CAS – Claims Adjustment		MDCH expects claim adjustment information when the value reported in Loop 2400 SVD02 (Service Line Paid Amount) is not equal to the value reported in Loop 2400 SV102 (Service Line Item Charge Amount).  MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference.